South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICAID BULLETIN

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TO: **Medicaid Providers**

SUBJECT: **Medicaid Updates**

- **I. 2007 Current Procedural Terminology (CPT) Update**
- **II. Modification to Billing Requirements for EPSDT Services on the Revised CMS 1500 Form**
- **III. Clarification of Nerve Conduction Studies Policy**
- **IV. Modification of the Preventative Care Services Billing Procedures for Covered Cancer Screenings**
- **V. Coverage and Billing Information for the Gastrostomy Button Device Feeding Tube Kit**
- **VI. Clarification of CPT Codes and Rates for the Administration of Vaccines and Immunizations in the "Vaccine Administration For All Children" (VAFAC) Program**

I. 2007 Current Procedural Terminology (CPT) Update

The South Carolina Department of Health and Human Services (SCDHHS) manual for Physicians, Laboratories, and Other Medical Professionals has been updated to conform to the 2007 Current Procedural Terminology (CPT) for Medicaid covered procedures as promulgated and published by the American Medical Association.

II. Modification to Billing Requirements for EPSDT Services on the Revised CMS 1500 Form

In the bulletin dated October 12, 2006, listing the information for each field on the CMS-1500 form, there was an error as to the information needed in field 24H. For reporting purposes, this field must be coded as follows:

N = No problems found during visit
1 = Well-child care with treatment of an identified problem treated by the physician
2 = Well-child care with a referral made for an identified problem to another provider

III. Clarification of Nerve Conduction Studies Policy

Nerve Conduction Studies are covered as medically necessary when performed with needle electromyography (EMG) studies to confirm the diagnosis. It is recommended by the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) that the nerve conduction study and a needle EMG be performed together to ensure an accurate diagnosis. Neurological testing procedure codes 95805-95999 include the technical component, interpretation, and the physician's professional services. Physicians performing only the interpretation must use the 26 modifier with the appropriate procedure code. All procedures must be medically justified.

Nerve conduction studies must be billed using CPT guidelines indicating each nerve and any/all site(s) along the nerve, not each site. Codes that indicate "each nerve" will multiply for payment, and should be submitted on one line with the number of tests (or hours) indicated in the “units” column on the claim form. Claims submitted with more than the allowed amount of units will reject with edit code 713. You may submit the edit correction form with documentation for medical review. If justified, reimbursement may be made to the provider.

IV. Modification of the Preventative Care Services Billing Procedures for Covered Colorectal Cancer Screenings

Effective for service dates on or after April 1, 2007, the SCDHHS will begin utilizing the Healthcare Common Procedure Coding System (HCPCS) codes for the billing of a screening Flexible Sigmoidoscopy and Screening Colonoscopy.

These screening services are covered for recipients from age 50 and older if they are considered low-risk, or age 40 and older if high-risk. A patient is considered low-risk if no risk factors are known and high-risk based on a personal history of polyps, ulcerative colitis, colorectal cancer and/or a family history of cancer. The colorectal cancer screening covered services and frequency limitations are listed below:

Description	CPT Code	Frequency Limit
Hemocult Test	82270	One per Year
Flexible Sigmoidoscopy	G0104	One per 5 Years
Screening Colonoscopy	G0105	One per 10 Years

V. Coverage and Billing Information for the Gastrostomy Button Device Feeding Tube Kit

Effective on or after April 1, 2007, the SCDHHS will reimburse CPT code 91299 Unlisted Diagnostic Gastroenterology procedure for the supply item Gastrostomy Button Device Feeding Tube. This service will be covered for recipients under the age of 21 when performed in the physician’s office setting to cover the cost associated with purchasing the device. Claims should be processed on a CMS 1500 form and include a copy of the invoice and appropriate documentation supporting the medical necessity of the device.

VI. Clarification of CPT Codes and Rates for the Administration of Vaccines and Immunizations in the "Vaccine Administration For All Children" (VAFAC) Program

The South Carolina Department of Health and Human Services (SCDHHS) reimburses for the administration of all vaccines provided through the VAFAC program. The VAFAC program, a federally funded program providing vaccine serum for children under the age of 19, began covering the Pentavalent Rotavirus Vaccine (PRV) in September 2006 and Gardasil®, the Quadrivalent Human Papillomavirus (HPV) (Types 6, 11, 16, and 18) Recombinant Vaccine in January 2007. Please refer to your "Dear VAFAC Provider" letter from the South Carolina Department of Health and Environmental Control (SCDHEC), Immunization Division, for any questions concerning availability or program specifics, or contact SCDHEC by telephone at (800) 277-4687.

The administration CPT codes 90471 – 90474 are covered for the administration of vaccines provided through the VAFAC program for recipients under the age of 19. For the administration of vaccines by injection, the following CPT codes must be used:

90471 Immunization administration for one vaccine (single or combination vaccine/toxoid), (Includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections). **This code will only cover the first vaccine administered.** The administration fee for this CPT code will be $13.00. Do not use this CPT code for reporting administration of oral or intranasal vaccines.

90472 Each additional vaccine (single or combination vaccine/toxoid), use 90472 in conjunction with code 90471. **This code can only be used twice per visit, regardless of the number of additional vaccines administered.** The administration fee for this CPT code will be $13.00.

With the addition of the PRV, SCDHHS is revising its reimbursement methodology to accommodate multiple intranasal and/or oral vaccine administrations. For the administration of the FluMIST® or PRV, by intranasal or oral, the following CPT codes must be used:

90473 Immunization administrations by intranasal or oral, one vaccine. **This code will only cover the first vaccine administered per visit.** The administration fee for this CPT code will be $3.00.

90474 Each additional intranasal or oral vaccine (single or combination vaccine/toxoid), use 90474 in conjunction with code 90473. **This code can only be used twice per visit, regardless of the number of additional intranasal or oral vaccines administered.** The administration fee for this CPT code will be $3.00. (90474 can be billed in conjunction with 90471 or 90473).

If you have any questions regarding this bulletin, please contact your Physician Services program representative at (803) 898-2660.

/s/

Robert M. Kerr
Director

RMK/bgwd

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